DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Outpatient Hospitals
Managed Care Plans
CSO Administrators
Regional Administrators

Memorandum No: 01-51 MAA
Issued: June 27, 2001

For Information Call:
1-800-562-6188

From: James C. Wilson, Assistant Secretary
Medical Assistance Administration (MAA)

Supersedes: 00-22 MAA
00-87 MAA

Subject: Update to the Resource Based Relative Value Scale (RBRVS) and Vendor Rate Increase for Outpatient Hospitals

Effective with dates of service on or after July 1, 2001, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2001 relative value units (RVUs);
- The updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- The Year 2001 additions of Current Procedural Terminology (CPT™) codes and Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes;
- Technical changes; and
- An appropriated two and one-tenth percent (2.1%) vendor rate increase.

I. Maximum Allowable Fees

In updating the fee schedule with Year 2001 RVUs and clinical laboratory fees, MAA maintained overall budget neutrality. The 2001-2003 Biennium Appropriations Act authorizes this two and one-tenth percent (2.1 %) vendor rate increase for MAA fee-for-service programs. The maximum allowable fees have been adjusted to reflect the changes listed above.

II. MRI/MRA

As detailed in Section C of the Outpatient Hospital Billing Instructions, all outpatient MRIs require Expedited Prior Authorization (EPA). The new 2001 CPT codes for MRIs are included in this requirement. The following chart lists the three-digit numerical code of the diagnostic condition, procedure, or service that meets the EPA criteria. This three-digit code should be **added to the end of 870000 to create a 9-digit EPA number**. Refer to pages C5-C8 of the Outpatient Hospital Billing Instructions for a full explanation of the criteria represented by each three-digit code.

CPT Code	Three-Digit Code Choices
70542	390
70544	301-309 or 390
70546	301-309 or 390
70548	390
71551	390
72195	341-342 or 390
73218	361 or 390
73222	361 or 390
73718	371 or 390
73722	371 or 390
74182	381 or 390

CPT Code	Three-Digit Code Choices
70543	390
70545	301-390 or 390
70547	390
70549	390
71552	390
72197	341-342 or 390
73219	361 or 390
73223	361 or 390
73719	371 or 390
73723	371 or 390
74183	381 or 390

III. PET Scans

A. MAA will cover Positron Emission Tomography (PET) scans only after prior authorization has been obtained. To request prior authorization send a written or fax request to:

Division of Health Services Quality Support
Quality Fee-For-Service Section
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-2262

B. The following CPT procedure codes for PET scans are covered after prior authorization has been obtained:

- 78608-78609, 78459, 78491-78492, and 78810

(continued on next page)

C. The following new PET scan codes have been added effective July 1, 2001, and will be paid "By Report." In addition, a number of current PET scan HCPCS codes listed in the 2001 HCPCS book have been discontinued effective June 30, 2001, by HCFA, and replaced with these new codes. Replaced codes are noted.

HCPCS Code	Replaced HCPCS Code	Description
G0210		PET Imaging whole body; diagnosis; lung cancer, non-small cell
G0211	**G0126**	PET Imaging whole body; initial staging; lung cancer, non-small cell
G0212		PET Imaging whole body; initial staging; lung cancer; non-small cell
G0213		PET Imaging whole body; diagnosis; colorectal cancer
G0214		PET Imaging whole body; initial staging; colorectal cancer
G0215	**G0163**	PET Imaging whole body; restaging; colorectal cancer
G0216		PET Imaging whole body; diagnosis; melanoma
G0217		PET Imaging whole body; initial staging; melanoma
G0218	**G0165**	PET Imaging whole body; restaging; melanoma
G0219		PET Imaging whole body; melanoma for non-covered indications
G0220		PET Imaging whole body; diagnosis; lymphoma
G0221	**G0164**	PET Imaging whole body; initial staging; lymphoma
G0222	**G0164**	PET Imaging whole body; restaging; lymphoma
G0223		PET Imaging whole body or regional; diagnosis; head and neck cancer, excluding thyroid and CNS cancers
G0224		PET Imaging whole body or regional; initial staging; head and neck cancer; excluding thyroid and CNS cancers
G0225		PET Imaging whole body or regional; restaging; head and neck cancer; excluding thyroid and CNS cancers
G0226		PET Imaging whole body; diagnosis; esophageal cancer
G0227		PET Imaging whole body; initial staging; esophageal cancer
G0228		PET Imaging whole body; restaging; esophageal cancer
G0229		PET Imaging; Metabolic brain imaging for pre-surgical evaluation of refractory seizures
G0230		PET Imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study

D. **Effective June 30, 2001,** HCPCS codes **G0126, G0163, G0164** and **G0165** will be discontinued.

E. HCPCS code **G0125** has a definition change: “PET Imaging whole body or regional; single pulmonary nodule.”

IV. Digital Mammography

Effective with dates of service on or after July 1, 2001, MAA will pay for digital mammography using the following new 2001 HCPCS codes (fees represent technical component only):

HCPCS Code	Description	Maximum Allowable Fee
G0202	Screening mammography producing direct digital image, bilateral, all views	$45.58
G0203	Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views	$45.34
G0204	Diagnostic Mammography, direct digital image, bilateral, all views	$45.58
G0205	Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views	$45.34
G0206	Diagnostic Mammography, direct digital image, unilateral, all views	$24.88
G0207	Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views	$24.88

V. Laboratory

The following state-unique code was added for the HIV Virtual Phenotype test and will be paid “By Report”:

State-Unique Code	Description
8999M	Infectious agent virtual phenotype analysis, HIV 1

VI. Osseointegrated Implants

Retroactive to dates of service on or after January 1, 2001:

- Outpatient hospitals must bill revenue code 278 and attach an invoice for the osseointegrated implant. Reimbursement is through a ratio of cost to charges (RCC).

VII. Medical Nutrition Therapy (formerly known as Nutritional Counseling Services)

Outpatient hospitals that bill for Medical Nutrition Therapy provided by certified dietitians should use the following codes.

These medical nutrition therapy services are allowed only for clients 20 years of age and younger as a result of a referral from an EPSDT provider.

State-unique codes 0910M and 0911M have been discontinued and replaced with the following CPT codes:

State-Unique Code (Discontinued for dates of service on or after 9/1/01)	CPT Procedure Code (Effective 7/1/01)	Short Description	7/1/01 Maximum Allowable Fee
0910M	97802	Medical nutrition therapy, individual, initial 1 unit=15 minutes	$11.49 per unit Max. of 8 units Per year
0911M	97803	Medical nutrition therapy, individual, subsequent 1 unit=15 minutes	$11.49 per unit Max. of 4 units Per day
N/A	97804	Medical nutrition therapy, group 1 unit=30 minutes	$11.49 per unit Max. of 2 units Per day

Attached are updated Outpatient Hospital Billing Instructions replacement pages.
To obtain this fee schedule electronically go to MAA's website at http://maa.dshs.wa.gov.

Please bill MAA your usual and customary fee.